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Primary care Receptionists: roles and collaboration with other primary health care practitioners in two French community health centers. (a qualitative study)

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List of Acronyms

AIDS: Acquired Immunodeficiency Syndrome

CCAS: Solidarity service of the Local government Centre Communal d'Action Sociale /

COVID 19: 2019 Novel Coronavirus

GP: General Practitioner

HCP's: Health Care Professionals

IPC: Interprofessional Collaboration

OECD: Organization for Economic Co-operation and Development

PASS: Permanent Access to Healthcare

SES: Socioeconomic Status

Abstract

Primary care Receptionists: roles and collaboration with other primary health care practitioners in two French community health centers (a qualitative study)

Background: Primary care is the central pillar of healthcare in which receptionists fulfil an essential role, shaping patient's access to health professionals. They are mainly portrayed as the face of the care team. Despite their level of importance in the team and in patient's pathway of care, there still exists some obstacles to their proper team integration.

Objective: To explore and expand the experiences and perceptions of general practitioners (GP's), nurses, receptionists and a clinical psychologist on the roles of receptionists in primary care and barriers to better team integration and collaboration between these primary health care professionals and receptionists.

Design, setting and participants: 18 Semi-structured interviews were conducted with five GPs, three nurses, one clinical psychologist and nine primary care receptionists from two French community health centers in the Ile de France region. Interviews were thereafter analyzed thematically.

Results: Receptionists reported a broad range of duties, which included administrative and supportive care work as they stated that they always try to acknowledge patient's emotional needs and help as much as they can. It was gathered that participants saw the roles of receptionists as vital in the team and in the center and even considered their involvement in specific roles. However, further discussions on the barriers to proper team integration revealed that as important as their roles were, they were not completely seen as part of the primary health care team. Participants stated that lack of training and patient confidentiality, unequal status with hierarchy perceived from lack of joint team meetings were obstacles to proper collaborative practices.

Conclusion: Although receptionists play a very important role which was acknowledged by all participants, French HCP's in general practice may not be able to take full advantage of the potential of sharing patient responsibility and learning with, from and about each other without first overcoming some barriers. Contextual barriers for team-based care approaches should be addressed in future research. Finally, to encourage interprofessional practices in primary care, future programs and interventions should focus on developing strategies and policies that will facilitate such practices in different healthcare systems.

Keywords: communication, General Practitioners, (GP's), healthcare professionals, interprofessional collaboration, primary healthcare, receptionists, teamwork

Résumé

Agents d'accueil en soins primaires : Rôles et collaboration avec d'autres praticiens de soins de santé primaires dans les centres de santé communautaires français (étude qualitative)

Contexte : Les soins primaires sont le pilier central des soins de santé et les réceptionnistes de soins primaires jouent un rôle essentiel dans les soins primaires, en façonnant l'accès des patients aux professionnels de la santé. Ils sont souvent présentés comme le visage de l'équipe soignante. Malgré leur niveau d'importance dans l'équipe et dans le parcours de soins du patient, il existe encore quelques obstacles à leur bonne intégration dans l'équipe.

Objectif : Explorer et élargir les expériences et les perceptions des médecins généralistes (MG), des infirmières, des agents d'accueils et d'un psychologue clinicien sur les rôles des réceptionnistes dans les soins primaires et les obstacles à une meilleure collaboration entre ces professionnels des soins de santé primaires et les agents d'accueils.

Modèle, cadre et participants : 18 entretiens semi-structurés ont été menés avec cinq médecins généralistes, trois infirmières, un psychologue clinicien et neuf réceptionnistes de deux centres de santé dans la région Ile de France. Les entretiens ont ensuite fait l'objet d'une analyse thématique.

Résultats : Les agents d'accueil ont fait état d'un large éventail de tâches, notamment des tâches administratives et des soins de soutien, car la plupart d'entre eux ont déclaré qu'ils s'efforcent toujours de reconnaître les besoins émotionnels des patients et de les aider autant que possible. Les participants ont estimé que le rôle des réceptionnistes était essentiel au sein de l'équipe et du centre, et ont même envisagé leur implication dans des rôles spécifiques. Cependant, des discussions plus approfondies sur les obstacles à une bonne intégration dans l'équipe ont révélé que, aussi important que soit leur rôle, ils n'étaient pas complètement considérés comme faisant partie de l'équipe de soins de santé primaire. Les participants ont déclaré que le manque de formation et le secret professionnel, l'inégalité de statut avec la hiérarchie et le manque de réunions d'équipe étaient un obstacle aux pratiques de collaboration.

Conclusion : Bien que les réceptionnistes jouent un rôle très important qui a été reconnu par tous les participants, les professionnels de la santé en médecine générale ne peuvent pas tirer pleinement parti du potentiel de partage des responsabilités des patients et d'apprentissage mutuel sans avoir d'abord surmonté certains obstacles. Les obstacles contextuels aux approches de soins en équipe devraient être abordés dans les recherches futures. Enfin, pour encourager les pratiques interprofessionnelles dans les soins primaires, les futurs programmes et interventions devraient se concentrer sur l'élaboration de stratégies et de politiques qui faciliteront ces pratiques dans les différents systèmes de santé.

Mots-clés : communication, médecins généralistes, professionnels de la santé, collaboration interprofessionnelle, soins de santé primaires, réceptionnistes, travail d'équipe.

Introduction

Interprofessional Collaboration in health care

The global need for healthcare and the accentuating demand for complex primary healthcare services has led to a network of Health care professionals (HCP's) and care givers that must always be prepared and ready to work together. [1] [2] For example, estimates from the USA show that given effective collaborative practice, up to 80% of preventive care could be performed by non-physician members of the general practice team [3] [4] and the World Health Organization (WHO), states that collaboration amongst health care practitioners strengthens health systems, improves patient's experience of care and health outcomes. [5] This highlights the importance of approaching patient care from a team-based perspective.

As early as 1988, the WHO study group on Multiprofessional Education of Health Personnel was calling for more interprofessional collaboration (IPC) to achieve a less fragmented and more effective approach to health care problems. [5] While collaboration is broadly defined as health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care; [6] [7] collaboration between professionals from a wide range of disciplines is known as interprofessional collaboration.

In a 2015 paper on inter-professional collaborative practice in healthcare, IPC was defined as an active ongoing partnership, often between people from diverse backgrounds, with distinctive professional cultures and possibly representing different organizations or sectors, who work together to solve problems or provide services. [8] Specifically considering the many different disciplines required to promote health and provide health care, the Robert Wood Johnson's foundation has defined effective IPC in a particular way. They see effective IPC as enhancing patient and family-centered goals and values, providing mechanisms for continuous communication among caregivers, and optimizing active participation in clinical decision-making within and across disciplines. Such collaboration is seen as fostering respect for the disciplinary contributions of each professional. [9]

Before moving further, it is of essence to distinguish between IPC and other types of similar Interprofessional practices such as teamwork, coordination, networking, cooperation and communication. To start, teamwork is defined as an adaptive and dynamic process that encompasses the thoughts feelings and behaviors amongst team members, while they interact towards a common goal. [10] A key difference between collaboration and teamwork is that shared identity and integration of individuals are less important in collaborative groups than in teams. [11] However, collaboration is similar to teamwork in that it requires shared accountability between individuals, some interdependence between them, and clarity of roles/goals. Inter-

dependence refers to the occurrence and reliance on interactions among team members where each is mutually dependent on another to accomplish his/her tasks.[12] As a process, collaboration; a) requires relationships and interactions between health professionals regardless of whether they perceive themselves as part of a team; and b) affects the results of teamwork as an outcome . [13] These notions insinuate that the act of bringing people together and calling them a team does not necessarily mean they will collaborate. Thus, collaboration is related to the concept of teamwork, although collaboration is not done in all teams. [12]

In coordination, integration and interdependence of members are less important and team tasks are regarded as more predictable, less urgent and less complex than in collaboration. [11] However, coordination is similar to collaboration in that it requires some shared accountability between individuals and clarity of roles, tasks, and goals. In networks, tasks are predictable, non-complex and non-urgent, so in networking, shared team identity, clarity of roles/goals, interdependence, integration and shared responsibility are less essential than in coordination. As a result, networks could be virtual in nature where members do not necessarily meet face-to-face, but communicate through email or online video/audio conferencing. Another important and integral element in interprofessional practice is cooperation. As seen in figure 1, compared with teamwork, collaboration, and coordination, cooperation is the activity that requires the least amount of shared purpose and dependence on team members.[14] A final key element is communication. It is what binds individuals within a workplace and one of the main mechanisms through which information is transferred. It involves interacting in whatever way works best for the team[14] [15] .

Even though these terms have similar connotations, they differ in their level of purpose and dependence.

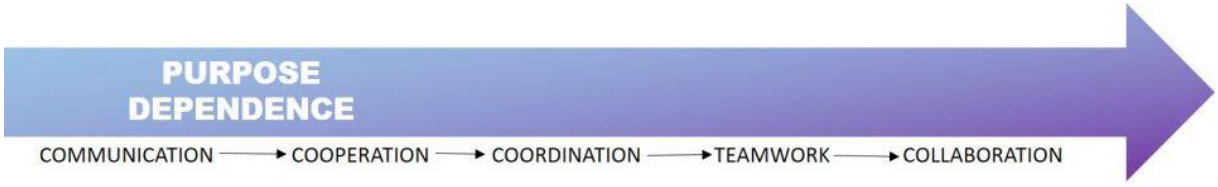

Figure 1: Differences in level of purpose and dependence.

Aside from the interprofessional practices discussed above, researchers and professionals also use interdisciplinary and multidisciplinary/multiprofessional teams as surrogate terms [12]. An interdisciplinary team in this context may be understood as a group of professionals from different medical disciplines, working interdependently in the same setting, mainly aligning resources and establishing cooperative projects. [16] [17] [18] Within a multiprofessional relationship, cooperation may be mutual and cumulative but not always interactive, while interprofessional blends the practices and assumptions of each profession

involved. [18] This means that although multidisciplinary teams involve several professions, members are unable to develop a cohesive/shared care plan as each team member uses his or her own expertise to develop individual care goals with little awareness of the other disciplines work. [16]

In summary, unlike both alternative/ surrogate terms discussed above, IPC involves a deeper level of working together, characterized by intensive interactions between professionals in health care settings and the development of a shared care plan which makes team members' aware of each other's' knowledge and skills. [19]. It should come as no surprise that an integrated approach to care through IPC in primary care is positively associated with the provision of safe and high-quality health and social care services [20] which is essential to promote and maintain the health of the population whilst improving service effectiveness. [21]

A large cross-sectional study of Australian general practices[1] that measured team climate in relation to chronic disease care and staff satisfaction, discovered that better team climate was associated with greater patient satisfaction. The study concluded that there is a positive correlation between collaboration, staff satisfaction and patient outcomes. [22] Another study of 15 hospitals in California documented lower in-hospital mortality rates for patients with Acquired immunodeficiency syndrome (AIDS) in nursing units where nurses were the primary care providers and collaboration with physicians were exemplary.[23]

These studies mainly focus on collaboration between health care practitioners, and rarely include administrative staff such as receptionists, however. A systematic review of qualitative studies in primary care aimed at identifying facilitators of, and barriers to, inter-professional collaboration in primary health care as perceived by other actors other than nurses, only reviewed studies on collaboration between pharmacists and mental health professionals.[24] This highlights that despite the importance of their role in the primary health care team, other non-clinical staff such as receptionists, are rarely included in studies examining inter-professional collaboration. There have been even fewer studies specifically looking at these actors in community health centers in France.

Primary care receptionists in health care

Article L6323-1 of the French Public Health Code defines health centers as local health facilities primarily providing primary care. In 2019, a document published by The Paris Observatory (L'observatoire de Paris) in conjunction with the 17 regional health agencies (Agences regionales de santé, ARS) in France stated that there are as many as 1831 health centers in France.[25] These centers provide care activities and carry out public health actions

[1] 654 general practitioners and mainly medical staff, 7505 chronically ill patients from 93 general practices in 6 Australian states and territories

such as preventive actions, diagnosis, health education, therapeutic education of patients and social actions in the center or in patients' homes. They are also very active in the areas of early childhood, family planning, adolescence which are essential aspects of primary care.[26] They equally provide multi-professional care with professionals such as physicians and nurses. These centers also rely heavily on medical secretaries and administrative staff such as receptionists. [27] [28] This is why the relative 'invisibility' of receptionists in primary care is paradoxical given their role and importance.

In most health care facilities and in this case health centers, patients must interface with receptionists first, before being able to access either physicians or nurses. This means receptionists are the first point of contact for patients accessing health care. [29] They not only serve as an interface but also manage demands while ensuring the clinic is run safely and efficiently. [30] Receptionists answer phones and welcome patients and as such play a critical role in the first impressions the individual calling or visiting will have before they transition from a 'person to a patient'. Receptionists in French health centers are also in charge of patient billing and thus process patients' social security cards (known as the *carte vitale*) to obtain important information such as their primary physician, social security benefits, supplemental insurance etc. [31] There have also been instances where the duties of receptionists have been expanded beyond traditional administrative roles [32] assigning them responsibilities for tasks normally attributed to nurses and doctors, such as temperature checks and triage/judgement calls on prioritizing patients.

Expanding receptionists' scope of practice is an example of task shifting, and occurred more frequently at the peak of the COVID 19 epidemic in some French health centers. Task shifting has been more broadly explored in the UK, compared to France. Beyond their administrative roles, receptionists in the UK have been shown to regularly undertake functions more directly related to patient health, in particular communicating test results and managing repeat prescriptions. [33] Another primary role of the receptionist is that of coordinating communication between multiple parties. Thus these receptionists have responsibilities for ensuring continuity of care by communicating with patients, doctors and sometimes external care providers. [34] Since communication is fundamental to teamwork, developing interpersonal communication skills is necessary for them to work effectively. [34]

Another study was carried out in the UK on the awareness of education and training for primary care receptionists. The results of the study showed that among all primary care workers, receptionists were the least likely to receive any further education as training is often not a criteria for their continued employment, unlike healthcare professionals who have a deontological obligation to engage in lifelong learning [35] Whilst receptionists are undoubtedly the most visible actors of the primary care workforce and required to work under

unprecedented levels of pressure and scrutiny, they are rarely given the opportunity to learn about primary care or medical terminology [30] [36] It becomes the responsibility of each receptionist to learn about the healthcare system and communication stills in order to do the job(s) assigned to them. For instance, medical receptionists need ability to be able to provide quick and accurate responses when scheduling patient appointments, requiring a strong understanding of pathologies, doctors' availabilities and patient's needs.[37] Medical receptionists in the United States, on the other hand, are required to have at least some first aid training and a high school diploma or GED certificate to be employed. [38]

Two studies on the roles of receptionists, one in New-Zealand and the other in Australia, showed that apart from their administrative duties, receptionists have also been known to provide supportive care to patients. [39] [40] They do this by building trust in their relationships and providing patients with emotional support. However, the work of receptionists has been largely overlooked by policymakers and undervalued by GPs and other staff, and receptionists have remained marginal members of the health care team. [41] [42] [40] Although there has been some research conducted on the roles of receptionists in primary care in other countries aside from France, [34] [43] [44] there still remains a significant gap regarding the perception these receptionists have of their role, and how their work is perceived by other health care practitioners. A better understanding of how receptionists perceive their roles and responsibilities could influence their efficacy. Moreover, knowing how other HCPs view the roles of receptionists within the team could help identify barriers and facilitators to their integration into the care team, which could in turn, ensure effective collaborative practice and better patient outcomes.

Objectives

To respond to this gap, this study has the following objectives:

1) to explore and expand our present understanding of the role of primary care receptionists in the primary health care team.
2) to explore and identify the perceived facilitators and barriers to team integration with other primary healthcare professionals (mainly nurses and General Practitioners)

To meet the above objectives, we asked two overarching research questions:

- **RQ1 Receptionists:** How do receptionists perceive their role in the health center and their experiences as a primary care team member?
- **RQ2 HCP's:** How do healthcare professionals perceive the role of receptionists within the health center.

Methods

To meet the objectives and answer the research questions, a qualitative study was conducted in two French community health centers (centers A and B) in two different communes in the Ile de France region. Centers A and B each have an annex respectively (centers A1 and B1). For the purpose of this research work, there will be no distinction between the participants interviewed in the annex of each center from those interviewed in the main location because all staff work in both depending on where they are scheduled to work a particular day. For example, a certain receptionist or HCP may work in the main health center (A) the first two days of the week, and work in the annex, (A1) the last three days of the week. This example also applies to Center B. In conclusion, centers A and A1 have the same staff and the same director of health. The same goes for B. That is why in this paper, centers A and A1 will be named A while centers B and B1 will be named B.

The main source of data collection was interviews with a variety of primary care staff (GP's, nurses, receptionists and a clinical psychologist) within these community health centers. As stated above, these community health centers are located in two very different Communes within Ile de France. Center B is a big community health center in terms of size and staff and has departments of medicine, radiology and a dental clinic. While also including these same three departments, Center A is a smaller center in terms of size and number of staff. At the time of the interviews, each receptionist, nurse, general practitioner and clinical psychologist were currently employed and working full time in both community centers. Given that the traditional primary care team consists mainly of GP's and nurses, the inclusion of a clinical psychologist who works very closely with the primary healthcare team in center A was thought to provide richer data. This was not possible in Center B because they did not have a clinical psychologist on staff.

Sampling

Participants were recruited using a purposive sampling technique and the following selection criteria:

a) Participants must have been currently working as receptionists or medical personnel in one of the two community health centers included in this study.
b) Participants should have a wide range of experience working within the community health center. They should have worked there for at least 5 months because this was considered sufficient time for them to have enough knowledge of their roles within the team.

Data Collection

Participants were first recruited through emails and telephone calls in the first two weeks of May and then semi-structured individual interviews were conducted in French between late-May and mid-June 2020. The interviews lasted between 30 and 60 minutes, were audio recorded and later transcribed in their entirety and important excerpts were translated into English. For the convenience of study participants, interviews were conducted during working hours (during short intermittent breaks) in break rooms, exam rooms and doctors' and nurse's offices. No interview was conducted during the general lunch break. During these moments, the interviewer ensured a calm and quiet environment for each participant. This allowed continuity of thought as participants transitioned from work to interviews and back to work again and also allowed observations of the participants in their workplace, thus providing additional insight into the responses provided by the participants. The interviewer did not have any prior relationship with the participants apart from being generally familiar with the health center. There were no financial or material incentives for participation.

Ethical considerations

Prior to the commencement of the interview, participants were ensured confidentiality and were given a consent form. The interviewer reiterated the purpose and method of the study and participants were informed of the freedom to withdraw from the study at any time emphasizing that data from the interview would be treated confidentially and confirming that personally identifiable information would be redacted in the transcripts. To this effect, each interview was labelled with a unique ID number and all identifying information was removed. In the text, pseudonyms are used for the verbatim to represent the views of the different participants. All participants gave their informed consent for the interview to be audiotaped and transcribed.

Data analysis

Using the transcribed interviews, a coding framework was devised by the primary researcher and a summary profile was created for each interview after reading and coding. The transcripts and summary profile were then entered into NVIVO 12. Themes became distinguishable across interviews and main themes began to emerge. Thematic reports were then generated and interview extracts were included to describe the roles of receptionists and the perceptions of other health care professionals in the primary care team.

Results

Socio-demographics

Of the twenty-two staff invited to participate in this study, eighteen accepted to be interviewed: nine were receptionists and nine were HCP's (5 GP's, 3 nurses and 1 clinical psychologist: see Table 1). All four staff who refused to participate gave a lack of time as their reasons for declining. Of the four staff who declined to participate, three were nurses from center A, therefore only one nurse was interviewed from this center. The nine medical receptionists interviewed ranged between 25 to 62 years old, were all female and had work experiences ranging from 1 to 15 years (the average length of employment was approximately 5 years).

Table 1: Demographic Data of Participants				
No. of participants in center and per profession	**Center**	**Length of employment (mean/ range in years)**	**Age (mean/ age range in years)**	**No. of participants with formal receptionist training**
5 Receptionists	**A**	6.2 (1-15)	59 (55-62)	0
2 GP's		16.5 (2-31)	47 (32-62)	N/A
1 Nurse		0.6	24	N/A
1 Clinical Psychologist		0.6	31	N/A
4 Receptionists	**B**	9 (1-10)	33 (25-42)	1
3 GP's		4 (1-4)	36 (34-37)	N/A
2 Nurses		2.5 (2-3)	27 (26-28)	N/A

Table 1: Description of participant's demographics

Seven of the nine receptionists had had professional backgrounds outside of healthcare before starting to work in the primary health care center (e.g. childcare worker, airport control agent, town hall receptionist, caterer etc.). This leads to the question of what led them to change careers. Four participants did not have a particular 'calling' to health care. For example, the receptionist who had worked in a primary school canteen for 30 years stated that she never wanted to leave her job but she was replaced, explaining: *"I was working in school catering, I was in charge of a team and then unfortunately, I was replaced. That's why I'm here. I never wanted to change my catering job." Karen, Center A.* Only three receptionists admitted that they specifically chose a career in healthcare because they had always had a passion for it and enjoyed meeting and assisting patients.

Most of the receptionists had not pursued higher education degrees nor had any formal training as receptionists before they started the job. Few had had any healthcare experience and in many cases, they lacked all three. All nine receptionists had learned "on the job" as time went by. Only one of them was trained as a medical secretary as opposed to a receptionist.

One receptionist described how difficult it was at the beginning since she was not trained and only learnt as time went by with the help of other receptionists. She gave this explanation:

I had no idea about the job before starting. I learnt as time went by, It was difficult at the beginning… ummm….it was not easy with no training but with time, I learnt thanks to the strong team spirit.
- Miracle, Center B

The participant who was trained as a medical secretary but hired as a receptionist said the decision to apply to the job was taken since there was no opening for a medical secretary position. In France, receptionists, as opposed to medical secretaries, are not required to undergo training before gaining employment. The difference between a receptionist working in health care and a medical secretary is therefore worth noting. The job of a medical secretary is both technical and relational. In the French health care system, a medical secretary, known as “secrétaire médicale”, is a trained staff who not only performs general administrative tasks like receptionists do, but in addition, carries out technical tasks such as writing of consultation, examination, surgical reports and management of inventories of drugs and medical devices[45] [46].

Major themes

Three major themes were derived from the data. Firstly, the analysis of participant’s perceptions of the roles and responsibilities of receptionists both in the center and in the health care team revealed two major themes: Importance and complexity of roles and beyond basic responsibilities which explores how these roles and responsibilities are linked to various health and social needs of patients (RQ1). The third and concluding theme identifies the barriers to receptionists’ better integration in the health care team (RQ2). In the following section, these three themes and corresponding subthemes will be discussed below.

1. Importance and complexity of roles

The participants, regardless of their role in the health center, all discussed the wide variety of tasks that receptionists carry out on a daily basis. Duties ranged from basic administrative processes, to managing patient behavior and patient flow in and out of the center. Some of the specific administrative duties included: scheduling appointments, answering phones, invoicing, gathering insurance and identification information, data entry etc. A receptionist described most of these tasks are routine:

“The days are a little bit similar, the principle is always the same, welcoming the patients, registering them, taking their vitals and insurance cards, and then directing them to their consultation. That's it, and on top of that, we do the telephone reception. That's it. After a typical day, it's also going to be the tidying up of the files. We can also occasionally do the processing of social security rejections. We can also do the archiving as well. And the invoicing as well.” Emma, Center B

Even though their tasks are routine, most receptionists still emphasized on the complexity of their roles by discussing how they have to juggle a lot of work all at once. The juggling they do between the demands of the practice and of patients creates considerable work tensions that are often invisible to other staff members. For example, care coordination, enacted through appointment scheduling, emerges as a complex role, organizational data regarding appointment availability and professional discernment of the appropriate clinical staff to direct patients to during emergency situations. The fact that sometimes have to simultaneously carry out these functions, makes their roles complex.

One receptionist also hinted about how complex her roles can be when it comes to managing patient's behavior:

"In relation to the patient, you have to respect people, we have patients who are very upset when they arrive but we always find a solution. For example, when I was working at the airport, people are always angry when they travel, so you have to react calmly. You don't have to get angry, but people have to be respectful."

- Precious, Center B

Since this receptionist had previously worked at the airport for 6 years, she understood the importance of remaining calm and learning how to control and manage difficult situations. In this example, the receptionist's previous professional experiences had taught her patience which she was currently applying to her present job.

During the interviews, the one participant who was trained as a medical secretary but employed as a receptionist noted a degree of self-analysis and thoughtfulness regarding the importance of her role as a member of the health care team. To buttress this point, she summed up the degree of importance this way: "to *tell you the truth, without us, the health center would not function. – Sophia, Center B*

Receptionists also viewed themselves as a fundamental actor in the patient pathway of care. They mentioned that they always had the urge to go the extra mile by being very attentive to patients' needs. Below is an example of a receptionist discussing the patients in her center:

"Even after the initial admission, we follow up with patients. We have to learn more about them to better serve them. There is a lot of follow-up. For example, patients with long-term chronic illnesses. We have to be very attentive to their needs. They are humans like us" – Olivia, Center A

Most of the receptionists felt their work had an essential impact. Providing an example, one receptionist expressed:

"Sometimes people might not like the doctor but if they like the way you are treating them and the care you show them; they will always come back." –Karen, Center A

The importance of the receptionists' roles was also acknowledged by all nine HCPs. One of the GPs who once worked for 3 years in private practice before joining the health center a year ago explained:

"Their roles are very essential. In an organization like this, we are lucky to have them. We need them in the team. When you're in private practice, there's no receptionist, we do it all by ourselves. The presence of these receptionists in this center is a very big plus and a great opportunity". – Dr. Smith, Center B

The clinical psychologist further described receptionists as the image of the clinic:

"They have a primary role because they are the first in contact with the patient, the face of the team. They're the ones who receive calls… they're at the entrance to healthcare. I find this a very important role, me in my opinion it's an extremely important role. Patients go through them and come back through them. They're sort of like a revolving door." Gabriella, Center A

Participants also frequently described receptionists as the "middle man" of the health care team and the ears and eyes of the team. One nurse gave this illustration:

"As for their role in the team, they are sort of the ears of the team. There is some information we do not necessarily have but since they see and hear a lot of things, they relay it back to us. It's sort of like an intermediary role. I think that this is once again very important because we need this information to completely understand a patient."- Elizabeth, Center B

The fact that receptionists are seen as the link/middle man in the team also points out the importance of effective communication. All respondents agreed that the role of receptionists in connecting the HCP's to the patients and vice versa, highlights the significance of communicating as a team as it allows correct information transmission. To reinforce how important communication is, a receptionist from Center A had this to say: "*The team needs us and we need them. We are the link in the team and communication is very important."-Olivia, Center A.*

2. Beyond basic responsibilities: responding to patients' health and social needs

In addition to the importance of the role of receptionists as patient-health center interface, receptionists also had other responsibilities. For one, respondents discussed task shifting and taking up public health roles as a way of responding to patients' health and social needs and a facilitator of better team integration. All respondents gave as examples, the extra roles receptionists had to take on at the peak of the COVID 19 pandemic while one receptionist discussed her responsibility for a social intervention introduced by the local government. This intervention seeks to help people who have no social security rights, gain access to healthcare. Examples of people who could be in this category are those with lower socioeconomic status/ without source of income, refugees and sometimes French nationals who might have just returned to the country after a very long time. Possible future roles such as involving receptionists in health promotion and prevention activities that could favour better team

integration, were also highlighted. Task shifting/ evolving responsibilities and public health roles will be discussed as sub themes below.

a) Task shifting/ evolving responsibilities

At the peak of the COVID 19 pandemic, both health centers were obliged to task shift as there was a lack of available personnel. One receptionist gave examples of activities she had to carry out during this period: *"…during the pandemic, we took patient's temperature, we gave masks, triaged patients according to their degree of urgency……. Normally, it's the nurses who do that. The medical people do it. It was not unpleasant. It was a good experience." – Olivia, Center A*. This suggests that task shifting could be a welcome idea. In addition, task shifting also made team members gain deeper insight into their various roles. One GP expressed how she never really gave the duties of receptionists much thought until the pandemic started:

"The COVID situation brought about many changes. We were forced to re-evaluate what our job duties were. Most of us never knew what the other is/was supposed to do. For example, I had no idea how many phone calls receptionists receive per day, how long they spend on calls etc. In reality, I have never done this kind of job. I see them do it, but never tried. We were obliged to understand better, each other's duties so that patient pathway of care could be more fluid. In a nut shell, we were more invested in understanding each other's roles, than before. Receptionists had to uh I don't know if I can put it this way, they had to carry out a medical reception instead of an administrative one." – Dr White, Center B

Another example of task shifting is the processing of social security rejections. The processing of social security rejections is a task mainly assigned to the accounting department of the health center but since receptionists are in charge of billing and invoicing, they sometimes get involved in the rectification of such errors. This means they have shared responsibilities with this department.

The final example would be the management of a social intervention called Pass. One receptionist talked about her role as responsible for this intervention:

"…… Since I started to work here, I've been in charge of the PASS program. So it's a network created in May 2019. The government allocates a yearly budget called OSMOSE to this program, and we (pause) people who do not have a right to social security, can have care, free for them, free of charge. I receive patients and assist them in filling a questionnaire, I examine the patient's situation and I then refer them. I also work with the CCAS which is the Solidarity Service of the Local Government, at the Town Hall, which takes care of seniors and people who do not have social security rights. This way, these people will get an AME card which is a medical aid card for free treatment. It's sort of some social work. This also applies to people who have no housing. This service provides them shelter. It's a service that helps those people". –Precious, Center B

The receptionist above explained that her reason for leaving her former job was because she wanted something permanent where she could learn new skills and knowledge. Enthusiasm and the desire to expand her scope of knowledge and practice stand as the main

explanation as to why she continues working on the Pass project even though the responsibility of working on this project was simply added to her job duties by her superiors.

Even though task shifting was mostly discussed by participants in center A possibly because they were much younger than those in B and may be more eager, enthusiastic and open to evolving responsibilities, one receptionist from A still insisted that they were also interested in taking up new roles but underexploited. However, one GP from center A questioned how motivated they were. He expressed that even though he perceives task shifting as good, he doesn't think receptionists in his center are motivated enough:

"Are they motivated themselves? I mean the will to truly go the extra mile. I'm talking about the team that's here, even if I don't know them perfectly, I feel they don't necessarily have this will to to..... They are always present like, I'm here, I've done my job, I don't want to change anything because I'm comfortable in my current environment. Not interested in doing more. That's it." –Dr Pepple Center A. This difference in perceptions between the HCP's and the receptionists in A could be as a result of bad communication. There might be communication barriers as GP's might be getting the wrong signals from receptionists which they end up misinterpreting and vice versa. This further expresses the importance of effective communication for the healthcare team to function well.

b) Public health roles

Regarding the eventual possibility of receptionists being involved in public health projects such as health promotion and prevention activities, all participants responded positively given some basic training (discussed below). A GP from center B illustrates his point:

"If a 14-year-old comes to the clinic and explains to the receptionists that he had unprotected sex, they must know how to handle this. It's a form of prevention that starts from them. Hmmmm it should be initiated by them. They can say oh don't be scared, yes you can see the doctor or the nurse, it's a form of psychological support. –Dr Smith, Center B".

As most HCP's were not so keen on involving receptionists in very specific clinical roles as some other countries like the UK, one GP proposed that they should be more involved in population health:

"I can say receptionists are unofficial caregivers. I ummmm believe once a patient passes through the door and comes into the centre, we should be ummmmm able to maximize every opportunity since this is a place for health care. This is a community health centre. If we can change this classic model of ummmm 20 minutes' consultation time with a patient, so so so number of patients is to be seen per day to for example 2 hours in the reception area with discussions over coffee plus a medical personnel who will come in to respond to people's questions. What are the living conditions of a person, how does that person live, pay his rent, eat? we need to go deep to understand how to thoroughly care for a patient. This can be done by receptionists by them asking questions to patients and directing them to the right services. One does not need to be a medical doctor to be able to discuss population health" –Dr White, Center B

A receptionist in Center A where receptionists were previously involved in health promotion and prevention activities, discussed this:

"the nurses would take walks with patients suffering from chronic conditions such as diabetes and sometimes the receptionists would also take part. I thought it was good, but we don't do that anymore. That way, we learnt about diabetes. Screening too. We go out on the street, talk to people and explain that there are ways to screen and bring them back to the centre but lately, we don't do that anymore. I don't know why"-Ava, Center A

She however added that she thinks in the team, receptionists are seen as below other HCP's and not recognized.

"A few years ago, I was part of a group where we collaborated on a psychosocial risk project, there was one person from each group, so a receptionist, a dental assistant, a doctor, we had a very thorough analysis, and it was interesting, but from the moment we had to propose things, it ended. As soon as we proposed things on the planning for example, or the interdepartmental meetings, small things that could be changed, that didn't cost a cent it became impossible. In my opinion, I think the reason is because we're at the bottom of the ladder, as if we were less than nothing. When you are a high school graduate or less, you can say the most important and sensible things and no one will listen to you. When you're well educated, you can say shit and it will be accepted. It's a sad thing." – Ava, 62 center A.

This opinion could be a reason as to why receptionists are no longer included in such projects in this particular center.

An analysis of participant's opinion in relation to the roles of receptionists in the above discussed themes, points to how important and sometimes complex, the roles of receptionists are in a team and in the health center as a whole. There were many similarities in how HCPs perceive the roles of receptionists and how receptionists themselves see themselves. To further understand how these roles can be put to better use in the team and how HCP's can effectively collaborate with receptionists thus reinforcing their importance in the team, we will be discussing the barriers enumerated by participants, to team integration.

3. Barriers to proper team integration and collaboration

Two main sub-themes emerged as factors impeding receptionist's full integration into the health care team: perceived hierarchy/unequal status from lack of joint team meetings and a lack of training and knowledge of medical terminology. These two sub themes will be discussed below.

a) Perceived hierarchy/ unequal status due to lack of joint team meetings

A lack of recognition from unequal status and perceived hierarchy mainly between the GP's and the receptionists was noted from the interviews. In addition, informal discussion with staff and some observation made by the interviewer also brought to light the fact that some degree of hierarchy existed between the older GP's and the receptionists. All three GP's from

center B attested to the fact that there was some form of hierarchy between receptionists and GP's, which is made obvious through the non-participation of receptionists in team meetings.

Everybody works in the same department but where is the team feeling at this time? We never have meetings together. In addition, between the doctors, we're mostly on first-name basis. For me, it's out of the question, not being on a first-name basis is out of the question but not the same for my most of my older colleagues. This and lack of joint meetings implies a form of hierarchy……...a form of uh uh distancing. Okay, maybe we studied longer, we think the doctor, is more prestigious.... but if we take away the doctor or the receptionist, the center won't function well. - Dr Smith, Center B

One receptionist also lamented about how she felt receptionists are not acknowledged nor treated equally because they are never included in team meetings and information was always withheld from them:

"*I think we're suffering from lack of recognition. We are not given the same level of importance given to the rest of the team. I think we're seen as a little bit like the disposable people.* There are things that happen at the center and we are not informed. *We're here, we don't have much to say. We don't even attend meetings with them"*

-Ava, Center A

On the other hand, the interviewer observed a lesser form of hierarchy between the receptionists and nurses. This observation of lesser degree of hierarchy was also in a way validated by all three nurses interviewed who said that the nurses and receptionists see themselves as a team and they were closely knitted. Hierarchy and unequal status as barriers were mainly mentioned by the receptionists in A and GP's in B although some form of informal observation carried out by the researcher also showed that hierarchy existed in both centers and not one.

As for receptionists in center A who felt they were not treated equally as team members, it is to be recalled that the age range of receptionists working in this center is between 55 and 62 and their years of work experience in the health center ranged from 1 to 15. This means most of them had spent their earlier years working in different sectors and had taken the receptionist job in their middle ages and thus had different expectations given their previous responsibilities. Blending into a new system after years of working elsewhere, could be a difficult feat to accomplish. Ava mentioned several times that she had once been a team leader at the recreation center where she worked and had worked on diverse projects. For example, she stated that she knows how to carry out an Overall Evaluation Criterion but when she proposed assisting on a project she was not given any audience.

b) Lack of training and knowledge of medical terminology

The second sub theme that emerged as a barrier was lack of training and knowledge. As above discussed, regarding the extent to which receptionists should be involved in patient care, all HCP's agreed that receptionists can be involved in health promotion and prevention

projects and social interventions. Some went further to explain that this is essential since a community health center has a large focus on preventive medicine. It was stressed however that appropriate training was crucial. Although some receptionists had lots of experiences before arriving at the health care center and the technical know-how, this was not considered sufficient. All HCP's agreed that training was essential to avoid errors and for better communication and effective collaboration. A nurse from center B explains why receptionists cannot be involved in health projects without proper training:

"we must have a minimum of basic knowledge when we are asked questions one must know the subject, one can't afford not to know. For example, we don't do a lot of health promotion projects here but for example in December, we always celebrate World AIDS day and I honestly don't see receptionists in charge of such or very much involved. I'm not saying they're stupid or anything but I'm not sure they have all the knowledge to be able to answer for example questions secondary school students may need answers for. I'm not sure they are trained to interact well in such circumstances." I think it would be necessary to train as a medical secretary. In France it's really the medical secretaries as long as there is confidential medical information, it's the medical secretaries. But normally here, we only have receptionists so they should not be in contact with medical information.
- Emelia, Center B

A GP who from center A also talks about the essence of basic medical training to reduce medical error:

"For me, there is a lack of training, especially for our staff, for our reception staff. If there was a different training, if they had basic training that allows them to acquire this level and reduce medical error .... at least in the knowledge of medical terms. I don't know, there's plenty of things to do. Some of them are willing…..……"- Dr Pepple, Center A

One doctor in center B talked about training as important and at the same time, encouraged the acknowledgement of rich experiences these receptionists might have:

"Sometimes these people know more about patients than we do. They can be trained and I know with their different backgrounds, we can all learn one thing or the other from each other. For God's sake these receptionists have very rich experiences due to diverse places they have worked before coming here. Why can't we draw from their rich well of knowledge" – Dr White, Center B

To further buttress this point, all HCP's were wary about sharing patient data with untrained staff. The French code of medical ethics describes patient confidentiality as a human right and all information obtained must be kept confidential. [47] This appeared as a sensitive aspect of healthcare for the professionals. One nurse in center B was direct about the fact that receptionists were not trained medical personnel neither are they medical secretaries so no medical information should be shared with them. Another nurse in the same center felt that the concept of patient confidentiality is a weighty issue and should not be taken lightly:

"For example, if a lady who is 7 weeks pregnant, walks through the door and the receptionists have to determine the urgency of the situation, I think it will be complicated plus how far does patient confidentiality go in this case?

Can I disclose my patients' information with receptionists who are not trained? For me, there are limits. These are very sensitive issues. – Emelia, Center B

Finally, to showcase the impact training has on better collaborative practices in healthcare, one GP from center B expressed how the minimal training receptionists in the center had, before task shifting during the COVID 19 pandemic, made their work progress easily. He said:

And I forgot to say, during the COVID period, for the first time they had to ask medical related questions to screen patients and for the first time, we trained them to ask if these patients have displayed any COVID symptoms so as to know where they should be directed. This was a very nice collaborative work we had together because it made our work as health care professionals easier. - Dr Smith Center B

Discussion

This study further explores and documents the perceptions of receptionists and healthcare professionals on the roles of receptionists in a primary care team and also to examine how they work with other professionals in the healthcare team. Main results indicate that receptionists view their roles as important and sometimes complex and other HCP's also see them as important members of the primary care team but may only complement HCP led-care, if some barriers can be addressed. This study proves that in French health centers, receptionists are indispensable for the center to function.

To further elaborate the importance of receptionists in a health care team, this study describes how exceptional circumstances, such as the COVID crisis, can lead to an increase in collaborative work between team members. The COVID crisis was an unexpected and new situation which no one had experienced before. This means that teams had to work better together than when performing everyday activities, as the stakes were higher, due to the severity of the pandemic and the future being unpredictable. Task shifting which can be likened to what occurs in medical deserts where there is lack of personnel and health care providers are obliged to share responsibilities was equally prioritized[48]. However, in a non-epidemic situation, centers in the Ile de France region may not be classified as medical deserts as this region has the highest number of healthcare workers, amongst other regions in the French territory. [25]

There have been stereotypes about females being naturally very caring and women in health care are suggested to orient their attention to the needs of others, taking care of organizational needs, co-workers, and practical arrangements for patients and their families, seeking to manage functional gaps in the work place. [49] One study in particular, researched how female medical students tend to show lots of empathy towards patients. [50] In this sense, women may naturally act in a more person-centered manner in general. The supportive role of showing patients empathy by going the extra mile which receptionist in this study identified

with, may therefore relate not only to their formal/administrative function, but also to inherent and traditional roles in being women. This is in agreement with opinions of receptionists interviewed, as they indicated that their role also involved meeting patient's psychological and emotional needs, through supportive care. This means they mostly saw themselves as informal care givers.

A study of six OECD countries suggests that world-wide shortages of primary care physicians and an increased demand for services, have provided the impetus for delivering team-based primary care. [51] This shows that the diversity of the primary care workforce is gradually increasing to include a wider range of health care professional. As receptionists in health care are seldom studied, the above mentioned study (OECD) does not provide insights into the ways in which receptionists in clinical settings such as health centers, can be included into the team and if collaboration with this set of professionals can be considered inter-professional or multidisciplinary. HCP's in this study mostly described how important the roles of receptionists are but never truly considered them as equal team members. For example, team meetings were rarely carried out with receptionists present. This means realistically, and considering the results obtained, involving receptionists given their roles and status in comprehensive shared decision making, may practically be impossible as they are not health care professionals. Therefore, coordination and communication may be more realistic and pragmatic objectives for receptionists' contribution to the healthcare team, given the definitions, as integration and interdependence of members are considered less important. However, as this study suggests the involvement of receptionists in public health activities such as health promotion and prevention programs, population health and not clinical roles, multiprofessional collaboration may be an important collaborative practice to be further explored and encouraged, as such practice does not require a shared clinical care plan/ decision making nor intensive interactions.

Moving on to some contextual information provided in this study, it was established that none but one of the receptionists had any official training before starting work. It is to be noted that potential lack of training (as faced by receptionists at the start of job) or information sharing, is an interesting element that complicates the receptionist job, and can have a significant impact on how the job is completed, especially given the amount of contact receptionists typically have with individual patients. Despite lack of training, receptionists must still learn how to sufficiently and competently handle their workload [30] [52] However, this lack of training may bring mistrust in the team as observed in this study. The only receptionist who had some medical training as a medical secretary said she sometimes worked in the dental department and to work in such department, the understanding of dental terminologies is of the essence. This in a way shows the importance of having basic medical training. On the

other hand, lack of basic medical training and knowledge shows that HCP's had the perception of not been on the same level of understanding with receptionists. Even though all agreed that receptionists should be involved in public health activities such as health promotion and prevention projects, HCP's still insisted and acknowledged that for better collaboration, training was essential.

Furthermore, one study in the UK described how receptionists in primary care carry out important clinical roles such as administering repeat prescriptions, even without specific training or recourse to any formal support [53] albeit with systems and protocols to govern the process. These responsibilities are placed on staff that are not required to undertake any related training. [54] Research has however shown how the sense of responsibility for their patients, felt by many receptionists, leads them to often make hidden contributions to ensure its successful completion. [55] In bridging the gaps between the intended process and the actual routine as it plays out in practice, they make extensive use of tacit knowledge and contextual judgements. [55] This example shows that placing this level of responsibility on untrained staff is unsafe, inadvisable, and leaves patients vulnerable.

In France, as it was made obvious through this study when asked to discuss their opinion on placing specific clinical tasks as the above in care of receptionists, HCP's were completely against such suggestion as only qualified medical professionals such as medical doctors, dentists etc. are authorized to prescribe medications [56] as also illustrated in the interview guide of this study (Annex 2).This was repeated several times during this study as all HCP's interviewed were against placing any serious clinical responsibility in the hands of unskilled staff. It would appear that the French health care system is more strictly regulated and less likely to leave medical decisions or actions in the hands of untrained workers. For better integration of all the actors in the primary healthcare team, training is therefore of the essence and training this set of professionals should be categorized as important. To further highlight the importance of training, a qualitative study carried out in Australia on medical receptionist' attitudes and beliefs towards preventive medicine, before and after exposure to training and support showed that when no training and support were given, receptionists developed negative views towards being involved in preventive medicine activities. When training and support were provided, these negative effects were abolished. [57]. For example, trainings in usage of medical terminology (as in the case of the United States where first aid training is compulsory) for proper communication is thus essential so they are able to be more effective in their role and better integrated into the healthcare team. [52] In addition, a multidisciplinary team approach to patient care represents a fundamental reconceptualization of health care delivery, such that a team-patient relationship replaces the traditional doctor-patient relationship. [58]To this effect, all HCP's discussed the importance of training to counter the

barrier of patient confidentiality as studies have shown that there has to be a balance between patient confidentiality and collaboration in multidisciplinary health care teams.

The results of this study also illustrate the importance of team communication, given the essential roles of the receptionist. Communication is a key element of team building and collaboration. A 2009 survey of medical receptionists' perception on the factors influencing specific medication errors carried out in Greater Glasgow concluded that good communication was essential given the role of receptionists as 'gatekeepers' for access to GPs. [34] Their role in communicating with multiple parties (patients, doctors, nurses and external care providers) further highlights the value of focusing on communication skills to encourage proper collaboration.[34] [37] Besides, lack of joint team meetings was highlighted in both centers as a barrier to proper team communication. Theoretical literature also suggests that for teams to be successful, there has to be a form of dynamic interaction/communication between team members who adapt interdependently and all have the same goal and vision. [59] [60] To bring this to reality, it is advised that team members have a clear appreciation of each member's role, not only roles but attention should equally be paid to the range of healthcare environments within which such is delivered so that contextual hurdles can be conquered.

Strengths and limitations

In this qualitative study, having representatives of different disciplines in primary health care participate, and not only focus on perceptions of receptionists is an added advantage. In addition, carrying out a qualitative study in a primary healthcare setting where quantitative studies are mostly done, is equally a strength of this study. In quantitative studies, human emotions and perspectives from both subjects and researchers are considered undesirable biases. [61] In this study however, these elements are considered essential and inevitable and treasurable as they add extra dimensions and colours to enrich the corpus of findings.

Secondly, given the lack of adequate literature/ minimal literature available on the work of receptionists and their collaborative practices with health care professionals in primary care and especially in France, this study illuminates this lack of research work on this group of professionals by invariably paving way for further elaborate studies as regards primary care receptionists. In addition, as this qualitative study was not exactly designed to yield statistically representative data, it nevertheless offers transferable data to studies in similar settings.

In terms of limitation, gender may have impacted the participant's descriptions of their care approaches and their perception of own role as this study only included female receptionists. This could have given room for selection bias as no male was interviewed. Another limitation to this study is that as the researcher interned under the heads of both centers, participants

might have been a bit frugal with the information they provide. For example, data gotten from respondents who said the team work was perfect and no form of hierarchy existed, might be biased given that the primary interviewer worked closely with the directors of both centers. Participants might have been a bit reluctant in their contributions.

Even though bias might have existed due to the fact that the primary researcher worked in these centers, it was also an added advantage as the researcher was able to truly observe the functionalities in these centers and have additional outcomes based on observation. This personal experience is believed to have enrichened this study as this gave better insight into understanding the context and setting and also interpreting the perceptions and views provided by these participants. After the initial analysis, the researcher was also able to go back into the field to ask more questions as multiple questions arose from the data provided but this could also have led to interviewer bias. In addition, the setting in which the interviews took place allowed participants' responses to directly reflect their actual daily practice.

Finally, as the interviews were conducted in French which is not the researcher's mother tongue, there might have been some language barrier, which may have contributed to a loss of complete and proper understanding of respondents experiences which in turn, may have led to complicated data comprehension and analysis. In addition, interview guides were translated from English into French and during the course of translation, some essential words or elements might have been misunderstood and not properly translated.

Conclusion

This study contributes to the sparse literature which exists on the roles and contributions of primary care receptionists in a health care team, in the context of a French community health center. The importance of receptionist to the team cannot be over emphasized. However, for receptionists to be fully integrated into primary health care teams, it is of essence that time should be dedicated to proper communication if possible, through joint meetings/development of appropriate direct communication tools and at least basic medical training as emphasized in this study. This is especially important for building shared views and overcoming perceived hierarchy and making every member, feel useful.

Having minimal interaction and communication with receptionists may cause HCP's in the included centers to miss out on the important and full advantages of potential sharing care responsibility which is observed in a multiprofessional environment. This may also may hinder the transitional of the current care approaches to a team based care approach which promotes learning with, for and about one another. This therefore suggests that focusing on the inequality in status or power of different team members, exploring and understanding the roles of one another and setting common goals, may contribute to a better environment for achieving what

is termed appropriate collaboration. Contextual barriers for team-based care approaches should be addressed in future research which should also include studies on collaboration between receptionists and primary care HCP's in bigger clinics and hospitals. As the actors interviewed in this study did not discuss the risks associated with task shifting and redistribution of roles. It is therefore recommended that further studies should elaborate on such risks, especially in the context of the French health care system.

To conclude, future programs and interventions should focus on developing strategies and policies that will facilitate interprofessional practices (including clinical and non-clinical staff) in different healthcare systems. In other words, future studies should discuss factors or barriers to training and the usage of proper communication tools.

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Annex 1

Research Questions and Interview Guide Receptionists: Primary care receptionists: roles and collaboration with other primary health care practitioners

Purpose: To explore the roles of medical receptionists in a primary health care team in a French community health center and perceived facilitators and barriers to interprofessional collaboration with primary health care professionals. (fostering greater interprofessional collaboration in primary health care)

Population: Primary care receptionists in 2 health centers in the Ile de France Region of France.

Abbreviations	
RQ	Research question
IQ	Interview question

Introduction: **If it's okay with you, I will be recording this conversation so that I can transcribe and refer back to it.**

Thank you for agreeing to speak with me today. I would like to ask you some questions about your roles and experiences working as a medical receptionist, how you view your role as gatekeeper in the medical community, towards patients and how you interact with other members of the primary health care team. I would like to learn about these things from your perspective – there are no right or wrong answers. If there are any questions that make you feel uncomfortable, feel free to tell me and we can skip or come back to those questions.

I also want to let you know that during the interview I may be taking additional notes or checking on the recording, but I want to assure you that my attention and focus is always on you and listening to your experience. Finally, I want to assure you that this recording will be used only for the purposes of this research thesis and you will be completely anonymous. Do you have any questions before we begin?

RQ1. How do receptionists view their role within the medical community?

To begin, can you please introduce yourself briefly?

Probes: How old are you?

What is your job title?

What is your level of education? Did you undergo any training before starting the job?

Any previous experience in primary care (other experiences in other areas?

IQ1-1. **How long have you been working as a primary care receptionist?**

Probes: If respondent has been working for a long time, one may ask if they were ever prompted to change jobs or not and why.

What prompted you to be a receptionist in health care? Passion, desire to work in healthcare? Background?

Justification/motivation as to why they have spent a certain amount of time in the job?

Any pre-established beliefs about the job before beginning actual work as a receptionist?

IQ1-2. **Tell me about what you did yesterday at work.?**

Probes: How do you see your job responsibilities/daily tasks towards patients and towards the primary care team as a whole? Interaction with patients living in the community?

Are there any overlapping duties with other healthcare professionals? Task shifting and experiences from such?

Can you describe how important you feel your role is to patients? How important do you perceive your role to be after the initial admission of patients into the system?

Can you share with me any difficult experience you might have had during the course of your work as a receptionist in a community health center? (patients, other HCP's?)

IQ1-3. **Can you discuss extra activities you have had to carry out aside from your traditional duties?**

Probes: Have you ever had to carry out extra duties?

Taking the Covid 19 pandemic situation as an example, were there times you had to do extra duties as opposed to your traditional duties as a receptionist?

If applicable, can you describe such experience and how you felt?

RQ2. What are some significant themes observed concerning experiences as a primary care team member?

IQ2-1 **How do you as a medical receptionist believe other team members view your role in the primary care team?**

IQ2-2 What are some skills and experiences you have gained from working as a team member in a primary healthcare team?

*Probes***:** How do you interact with other healthcare professionals?

In what ways do you think this job has added to your overall experience, working in a primary health care team? *(Experiences gained from formal teamwork trainings or from every day experiences?)*

Can you highlight any possible future roles that might foster better integration into the health care team?

What are some unnecessary tasks/roles you would like to be abolished? ***Closing Comments****:* Do you have any further comments or questions? Thank you again for taking time to meet. I really appreciate you sharing your experiences with me today.

Annex 2

Research Questions and Interview Guide HCP's: Roles of primary care receptionists and collaboration with other primary health care practitioners

Purpose: To explore the roles of primary care receptionists in a primary health care team in a French community health center and perceived facilitators and barriers to interprofessional collaboration between them and other primary health care professionals. (fostering interprofessional collaboration in primary health care)

Population 2: Actively working Nursing practitioners, General practitioners (GPs) and clinical psychologists in 2 community health centers in the Ile de France Region of France.

Abbreviations	
RQ	Research question
IQ	Interview question

***Introduction**:* Thank you for agreeing to speak with me today. I would like to ask you some questions about your perception of the roles of primary care receptionists as part of the primary health care team. I would like to learn about these things from your perspective – there are no right or wrong answers. If there are any questions that make you feel uncomfortable, feel free to tell me and we can skip or come back to those questions.

If it's okay with you, I will be recording this conversation so that I can refer back to it. I also want to let you know that during the interview I may be taking additional notes or checking on the recording, but I want to assure you that my attention and focus is always on you and listening to your experience. Finally, I want to assure you that this recording will be used only for the purposes of this research thesis and you will be completely anonymous. Do you have any questions before we begin?

RQ1. How do you as a medical professional view the role of receptionists and care approach as part of the primary healthcare team?

IQ1-1 To begin, can you briefly introduce yourself please?

Probes: How old are you?

What is your job title?

IQ1-2How do you perceive the roles of receptionists as gate keepers and as part of the primary health care team?

1Q1-3 To what extent do you think medical receptionists should be involved in patient care?

Probes: What is your opinion about delegation of specific clinical tasks?

Taking the Covid 19 pandemic as an example, was there any time you were obliged to work as a team with medical receptionists on extra tasks different from their traditional tasks?

Can you please highlight possible future roles or responsibilities that could encourage better team integration of receptionists into the primary care team?

RQ2. In your opinion, what are some possible factors influencing the collaboration of primary care professionals with receptionists.

Closing Comments*:* Do you have any further comments or questions? Thank you again for taking time to meet. I really appreciate you sharing your experiences with me today.